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ABSTRACT

The case study describes the progress of a psychotic trainable mentally retarded child who at age seven entered a day psychiatric hospital for disturbed children with average intelligence. The boy's therapist describes changes in the child's peer interaction, academic performance, group psychotherapy participation, and psychological test performance (which suggested learning disabilties rather than retardation). (CL)

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TREATMENT OF A PSYCHOTIC TRAINABLE RETARDED CHILD IN A DAY HOSPITAL FOR CHILDREN WITH AVERAGE INTELLIGENCE

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Persons in the mental health profession with few exceptions seem to have difficulty in providing adequate services to the emotionally disturbed mentally retarded patient. Two aspects of these problems seem to be paramount. First, the emotional disturbance often is not brought to the attention of the mental health specialist until it is so deeply entrenched that the prognosis using most of the techniques of psychotherapy is dim. Second, mental retardation even in its milder forms is anxiety provoking in many persons of above average intelligence and mental health professionals are no exception. The predominant defense against this anxiety is the rationalization that since the patient has limited verbal skills there is little reason to attempt psychotherapy. The present authors have been guilty of this attitude. However, two years ago advocates for the mentally retarded persuaded our treatment facility to accept an eight year-old trainably retarded psychotic child for day hospitalization. We accepted this child with the understanding that there would be a case conference in three months to discuss whether this placement was appropriate.

Richard Benson at the time of his referral was an eight year-old black male. He stood 4'6", wore thick glasses and appeared dischevelled.

Richard's early history was very chaotic. He lived with his natural parents until the age of 4½. The only developmental milestone his mother can recall is that Richard drank from a cup at 8 months. Hospital reports indicate he was hospitalized with chronic diarrhea at five months.

Mr. and Mrs. Benson are limited both intellectually and emotionally.

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Richard Benson Sr. is illiterate and has been sporadically employed. Carolyn Benson completed the seventh grade and periodically works. The family depends upon public assistance. Their marital functioning is characterized by instability. In two recent years the Bensons separated and reconciled three times. The consistent pattern embodies Ms. Benson leaving and becoming sexually involved with another man. When this relationship terminated, Mr. Benson readily welcomes her back and their relationship continues. After one such reconciliation both Bensons were treated for syphilis: Mrs. Benson secondary syphilis and Mr. Benson primary syphilis.

Richard, under the advisement of social services, was voluntarily placed into foster care. The Bensons had been evicted from their housing and social services placed Richard and his two younger sisters. At that time Richard was 4½, Ellen 2½ and Sharita 6 months.

At the time of his first foster placement Richard did not speak intelligibly and was not toilet trained. Additionally his world was optically confusing. Richard is legally blind and the Bensons had not provided corrective lenses during his first 4½ years.

Richard and Ellen were placed into the Wilson home - Sharita, 6 months was placed elsewhere. The Wilsons found Richard to be generally uncontrollable. He ate compulsively - devouring huge quantities of food then devouring more. He did not sleep during the nights. He would either awaken screaming or go wandering around the house. Richard was enuretic day and night and his entire vocabulary consisted of four letter obscenities which he used profusely. When the Wilsons attempted to discipline him, Richard had tantrums, screaming and flailing. He was hyperactive, never remaining still. He was destructive to himself and others.

After a year passed Richard's relationship with Ms. Wilson intensified. His cursing and aggressivity diminished. He still required close supervision, but, he was maintainable. However, without the close supervision of Mrs. Wilson, Richard would again exhibit bizarre uncontrollable behavior. After 2½ years Mrs. Wilson for

health reasons needed to take an extended vacation. It was felt Richard could not be maintained without a constant mother figure. Richard experienced another separation and was re-placed into another foster home.

As Richard adjusted into the Carwall home his sleepless nights and overall aggressiveness continued. However, he did not lose urinary and bowel control. During this time, Richard made some home visits to his natural parents. He would regress during these weekend visits and return wearing diapers. An observing social worker noted that the Bensons were "cruel" to Richard and were very negative in their approach to him.

Richard entered kindergarten in September 1972. At the age of five it was evident that Richard was inappropriate for his class. His academic and social retardation and bizarre disruptive behavior warranted his dismissal and a recommendation that another placement be sought.

In December of 1973, Richard was placed in an elementary trainably retarded class. He adjusted well until May 1974 when he began fighting and hitting. In October 1974 he was suspended and complete exclusion was threatened. His teacher reported he was obsessed with foods;found him ravaging through garbage cans, noted that in the bathroom he smeared his feces and labeled his overall competence as that of a 3½ year-old. At this time Richard was 7½. In early 1975 Richard was referred to New York Hospital for candidacy for our Day Hospital Program.

Our intake worker interviewed Richard and saw him as a severely traumatized child whose retardation was due in part to environmental deprivation. In a workup completed three months previously by the school psychologist he had been evaluated with an overall IQ of 42 on the Wechsler Scale. There was evidence of organic dysfunction and perceptual-motor impairment.

The population of the Day Hospital at that point consisted of severely disturbed children with average intelligence. After much discussion it was determined that Richard would be provisionally accepted pending evaluation three months later.

The New York Hospital Day Hospital Program can be explained in terms of

a milieu therapy approach. The objective of this approach is to help the child by identifying the critical areas in his or her adaptation to the day hospital environment. Once these areas are identified an attempt is made to manipulate them to facilitate the child's personality growth.

Three goals are inculcated within this approach: 1)it is important that the child's acting out behavior be curtailed. It must be communicated to the child that the staff will not permit him or her to lose control of their behavior. Secondly, it is important that the child be aware of emotional acceptance by the staff. When the child realizes that their behavior can be controlled and that despite their difficulties they are accepted, then their basic trust escalates and their anxiety lowers. When the children feel more comfortable in the environment they are able to engage in activities and begin to gain competence with difference interactions they have with the environment. The engagement and competence lays the foundation for a heightened sense of autonomy, initiative and self-concept.

When Richard entered the program, he was not able to form any relationships with the staff and spent much of his time exhibiting bizarre attention seeking behavior. He personified inanimate objects and talked to his hands. He was obsessed with foods and kitchens. He had unpredictable tantrums in which he flailed his body.

As his therapist I spent most of the day with him. After a month Richard began to verbally relate. Food and the regularity of reinforcement was a key in establishing trust. Effort was spent in purchasing appropriate games and learning materials for a child who functioned at about an age of three. Richard began to involve himself with these games and puzzles and his bizarre behavior and tantrums diminished. I kept daily telephone contact with the foster mother and Richard was rewarded at home depending on his behavior in the program. In addition, family visits were made monthly and it was communicated to Richard that we were trying to establish a consistency of approach in his home and school environment. It was believed that for such a confused child it would be beneficial if his behavior

elicited similar responses in school and at home. Stellazine was prescribed in a low dosage to help Richard be less anxious and help him integrate his incoming perceptions of the environment.

After four months in the program, Richard's relationship with me intensified. In one moment of anxiety he yelled for me calling me Mom. His talking to his hands and personification of the inanimate continued to diminish. His foster family reported that he no longer suffered insomnia or wandered around the house following nightmares. His tantrums and aggression decreased and for the first time he began to positively relate to his younger foster brothers and sister. Richard still was not able to relate positively to his peers in the hospital program. They were threatened by his psychotic behavior and academic retardation and avoided him.

We examined his difficulties in peer interaction and decided to place Richard in a section of our program in which the children would be younger than Richard. This required Richard to be separated from me for most of the day. A staff member in the other section was designated as Richard's advocate. After a difficult transition, because of the lessening of time he spent with me, Richard began to show improvement and began to interact with peers. He was now ready to engage in different milieu activities.

Richard was able to cope with three hours of education per day. A learning disabilities consultant worked with him daily. She noted that he had organic impairment in the areas of fine motor and visual motor coordination. The consultant labeled his strengths in the realms of auditory, kinesthetic and language functioning. Within one year, Richard who did not know the letters in the alphabet began to read. The consultant has used different media to help Richard use his strengths. She employed tape recorders and tactile letters. Richard spends one-half hour per day with the consultant and 2½ hours in a group setting for class. Initially Richard could only work, when he had one-to-one attention from the teacher. At other times,

he would be very disruptive to his classmates. However as he has spent more time in class and began to read, he has become capable of working autonomously in some areas.

Richard also is involved in the group activities of art therapy, psychomotricity and group psychotherapy. In each activity his progress has paralleled his ability to positively interact with others. In the motor area Richard has gross and fine impairment. Initially he took much time mastering simple tasks. He was very anxious and threatened by others. Recently Richard has shown gains and permitted other children to help him with tasks. In his group art session a similar pattern emerged with Richard increasingly more able to participate in group activities.

His group psychotherapy participation has improved. Previously he would be very threatened by others and demand total attention of the group therapists. Lately, he has been able to control his impulses and has been able to express his feelings to his peers.

As mentioned before Richard's relationship to me, his individual therapist, has intensified. He has non-verbally expressed this relationship in his individual art therapy sessions. The art therapist relates that in his first sessions Richard did much testing to discover if it was a secure environment. After he felt more comfortable he began to express his feeling through his drawing - his other modes of expression were either inaccessible to him or inappropriate in terms of the program. As weeks passed he expressed his feelings towards his foster family and natural parents and his burgeoning relationship with his male therapist.

Initially, Richard was unable to relate during his individual sessions verbally. Much of the time we spent together was in play therapy in which Richard expressed his feeling in psychotic symptoms. Now, Richard is able to verbalize many of his feelings as opposed to simply acting them out. He has expressed a desire to make friends. He also has been able to talk about his anger towards his natural parents and his fear of separation. During this past summer, there was a large staff

turnover and Richard became very anxious and insecure. His anxiety was expressed in his stealing his foster parents' car keys and housekeys and bringing them to the day hospital program. He was able to link these events to his fears of being sent away. Every few months, Richard visits with his natural parents under the supervision of myself and his caseworker. During the last session Richard was able to express his anger towards them about a forgotten birthday gift and also verbalized his anger about their not being able to take care of him.

Richard was retested by a psychometrist and her findings stated that his improvement is marked. Four months previously he was overtly psychotic during the testing and could not cope with standardized tests.

The psychologist feels that the usual instruments cannot do justice to Richard's potential. His lower scores were on picture arrangement and block design. These scores highlight the severity of the visual perceptual disability which is based on organic features. His verbal IQ on the WISC-R was 55 and the performance 58. His best score, picture completion, would be consistent with an IQ of 74. His performance on the CAT was in keeping with a child whose mental age is in the 6 year range. On the Rorschach he was able to give some good popular responses typical of an early latency age child and these responses at times incorporated human movement which requires some degree of insight in order to be seen on the cards. Keeping in mind his recent psychotic state and the magnitude of gain from an initial referral IQ of 42 in his first 16 months in the program, the psychologist was optimistic that Richard might achieve a borderline or low normal score with continued Day Hospital treatment. His performance at home has improved and his relationship with his foster siblings are more appropriate. Before Richard was referred to the Day Hospital program Ms. Carwall, his foster mother, was considering transferring him because she was receiving no outside help for this child due to his cognitive lacks and emotional impairment. There was no program which could cope or provide for this child. Without day hospitalization it is inconceivable that Richard could have been maintained in any home. Institutionalization would have been the necessary

recourse.

The disadvantages of institutional care have been well documented. Studies have shown that many institutionalized children remain in institutions for the rest of their lives. Richard's treatment cost for both the day hospitalization and aid to his foster family will cost the government $100,000 until he is eighteen. Institutionalization costs would amount to $225,000. It is conceivable that Richard may be able to be able to become a working member of society. He will probably always need some outside help, whether it be in terms of some regular therapy or a supportive familial setting. However, the costs to society will be decreased and more importantly the chance that Richard will gain competence and feel himself as productive are greatly increased.